

TITLE	Health Consultations
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee – 25 September 2012
WARD	None Specific
STRATEGIC DIRECTOR	Heather Thwaites, Strategic Director of Development and Regeneration

OUTCOME

That the Health Overview and Scrutiny Committee are informed of the current “live” health consultations.

RECOMMENDATION

- 1) To decide on which of the “live” Consultations the Committee would like to be consulted on and respond to prior to the deadline dates.
- 2) Members are asked to discuss the consultation on joint strategic needs assessments and joint health and wellbeing strategy guidance and agree a response to be submitted by Officers, in consultation with the Chairman, on behalf of the Committee following comments made at the meeting, by the deadline of 28 September 2012.

SUMMARY OF REPORT

This paper provides an overview of “live” consultations in relation to health policy as of 3 September 2012.

Department of Health ‘live’ consultations

Details provided on the “live” consultations have been taken directly from the Department of Health website.

For further information on consultations please refer to the Department of Health website, see link below –

<http://www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm>

1. Consultation on joint strategic needs assessments and joint health and wellbeing strategy guidance

Launch date: 31 July 2012

Closing date: 28 September 2012

The Department of Health is consulting on this draft guidance to ensure that it is clear and fit for purpose in supporting health and wellbeing boards and their partners in undertaking and contributing to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) within the modernised health and care system from April 2013.

It is also an opportunity for the Department of Health to seek views on what further supportive materials health and wellbeing boards would find useful in undertaking JSNAs and JHWSs; which the Department of Health will work with sector-leaders to develop.

The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. This draft statutory guidance explains these duties and powers. In particular, the draft guidance lays out:

- the statutory duties which underpin JSNAs and JHWSs to be undertaken by clinical commissioning groups and local authorities through health and wellbeing boards from April 2013;
- explains how JSNAs, JHWSs and commissioning plans fit together in the modernised health and care system; and
- sets out how the JSNA and JHWS process will enable the NHS and local government, working with their community and partner organisations, to make real improvements to the health and wellbeing outcomes of local people.

See attached **Appendix 1** for the full consultation document.

Responses to the consultation document and the specific consultation questions should be **emailed to**: Freya Lock, JSNA and JHWS development lead at JSNAandJHWS@dh.gsi.gov.uk

Or by hard copy to:

Freya Lock
JSNA and JHWS development lead
People, Communities and Local Government
Department of Health
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Tele: 0207 972 4237

<http://consultations.dh.gov.uk/local-government/jsnas-jhws-draft-guidance>

2. Consultation on a new adult safeguarding power for local authorities

Please note that this public consultation was originally highlighted as a consultation item at the previous HOSC meeting on 2 August 2012. Members may wish to consider responding to this consultation.

Launch date: 11 July 2012

Closing date: 12 October 2012

The Draft Care and Support Bill includes a proposed new duty on local authorities to make enquiries where there is a safeguarding concern. It states that local authorities “must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken.”

This Department of Health consultation seeks views on whether or not there should be a new power to support this duty. It could be in the form of a power of entry which will enable the local authority to speak to someone with mental capacity who they think could be at risk of abuse and neglect, in order to find out that they are making their decisions freely.

The draft Bill contains a number of proposals, including a duty of co-operation and partnership working between local authorities, police and health services. The Department of Health does not want to introduce further powers of entry unless a compelling case can be made.

See attached **Appendix 2** for the full consultation document and **Appendix 3** for the draft response paper drawn up by Officers for the HOSC to consider.

Responses to the consultation document and to the specific consultation questions should be **emailed to:** SafeguardingConsultation@dh.gsi.gov.uk

Or by hard copy to:

Quality and Safety Team
Department of Health
124 Wellington House
133 -155 Waterloo Road
London SE1 8UG

<http://www.dh.gov.uk/health/2012/07/safeguardingadults/>

3. Consultation on proposals for commissioners to secure best value for NHS patients

Launch date: 15 August 2012

Closing date: 26 October 2012

The Department of Health is consulting on **Monitor's**¹ new regulations for the NHS Commissioning Board and the Clinical Commissioning Groups to protect patients' interests by ensuring that commissioners deliver best value on procurement, patient choice, competition and managing conflicts of interest.

The consultation sets out the following requirements to:

¹ Monitor was established in January 2004 as the independent regulator of NHS foundation trusts. It is independent of central government and directly accountable to Parliament. The Health and Social Care (Act) 2012 establishes Monitor as the sector regulator for health care services. From 2013, it will be responsible for regulating all providers of NHS funded services in England. Its main duty will be to protect and promote the interests of people who use health care services by promoting the provision of health care services which is economic, efficient and effective; and maintains or improves the quality of services.

- ensure good procurement practice by commissioners (including requirements to act transparently, avoid discrimination and purchase services from the providers best placed to meet patients' needs);
- ensure that commissioners enable patients to exercise their rights to choose as set out in the NHS Constitution;
- prohibit commissioners from taking actions that restrict competition where this is against patients' interests; and
- to ensure that commissioners manage conflicts of interest and that particular interests do not influence their decision-making.

Responses to the consultation document and to the specific questions should be **emailed to:** pccr.consultation@dh.gsi.gov.uk

Or by hard copy to:

The Sector Regulation Team
 Room 229, Richmond House
 79 Whitehall
 London
 SW1A 2NS

4. Consultation on the new licensing regime for providers of NHS services

Launch date: 15 August 2012

Closing date: 22 October 2012

This Department of Health consultation is about Monitor's new licensing regime. The issues covered by the proposals include:

- who will be required to hold a licence from Monitor;
- the circumstances in which providers who are licensed can have a say in any changes to the standard conditions in their licence; and
- the fines Monitor will be able to impose if a provider breaches its licence conditions, delivers services without a licence or fails to supply Monitor with required information.

Monitor's proposals include a modular set of provider licence conditions containing seven sections. These are summarised as follows:

1. General conditions.
2. Licence conditions setting obligations about pricing.
3. Licence conditions setting obligations around choice and competition.
4. Licence conditions to enable integrated care.
5. Licence conditions to support continuity of care.

6. Governance licence conditions for NHS foundations trusts.

7. Interpretations and definitions.

Some of the sections will apply to all licence holders and some of which will apply only to certain types of licence holders, for example NHS foundation trusts.

The Department of Health and Monitor are working together to enable Monitor to bring the new licensing regime into force for NHS foundation trusts from April 2013 and for other providers of NHS services from April 2014.

Responses to the consultation document and to the specific consultation questions should be **emailed to:** pccr.consultation@dh.gsi.gov.uk

Or by hard copy to:

The Sector Regulation Team
Room 229, Richmond House
79 Whitehall
London
SW1A 2NS

5. Consultation on the arrangements for consideration of proposals on the fluoridation of drinking water

Launch date: 4 September 2012

Closing date: 27 November 2012

Under the Health and Social Care Act 2012, responsibility for conducting consultations on proposals for new fluoridation schemes, or the variation or termination of existing fluoridation schemes, will transfer to local authorities from 1 April 2013.

This consultation seeks the views of local authorities, NHS commissioners, public health professionals, service providers, equality representatives and all other interested parties on the future arrangements for consulting on proposals for fluoridation schemes

Responses to the consultation document and to the specific consultation questions should be **emailed to:** amit.bose@dh.gsi.gov.uk

Or by hard copy to:

Amit Bose
Department of Health
Skipton House
80 London Road
London SE1 6LH

<http://www.dh.gov.uk/health/2012/09/fluoridation-of-drinking-water/>

Reasons for considering the report in Part 2

N/A

List of Background Papers

Appendices 1 to 3 attached

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Date 3 September 2012	Version No. 1

DH CONSULTATION ON JOINT STRATEGIC NEEDS ASSESSMENT AND JOINT HEALTH AND WELLBEING STRATEGIES Draft Guidance

1. Introduction

The Department of Health has published a consultation document on guidance for implementing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and the responsibilities of Health and Wellbeing Boards.

2. Purpose

The Health and Social Care Act 2012 ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

3. Context

In the Act, the Government has set out a new vision for the leadership and delivery of public services – that decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. JSNAs and JHWSs are an important means by which they can achieve this.

The aim of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning.

Local authorities and clinical commissioning groups (CCGs) have an equal and joint duty to prepare JSNAs and JHWSs, through the health and wellbeing board. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process.

The NHS Commissioning Board (NHS CB) must participate in JSNAs and JHWSs. Someone who is not from the NHS CB can act for it. This could be someone from a clinical CCG, if the health and wellbeing board agrees.

4. Using JSNAs and JHWSs

JSNAs and JHWSs are fundamental to the new system because of how they are used, and the evidence base they provide for the planning of services.

CCGs, the NHS CB, and local authorities' plans for commissioning services must be informed by JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWSs, CCGs, the NHS CB and LAs must be able to explain why.

CCGs must also involve the health and wellbeing board in the preparation of (or when making significant changes to) their commissioning plans. CCGs must consult health and wellbeing boards on whether their commissioning plans take proper account of the JHWSs. When asked, health and wellbeing boards must give a view on this, which must be included in the published plan. It would be good practice for local authorities and the NHS CB to also involve health and wellbeing boards when developing their plans for commissioning to make sure that each plan is informed by the JHWS.

If a health and wellbeing board thinks that a CCG has not taken proper account of the relevant JHWSs it can make this known in very clear and certain terms to the CCG, and also to the NHS CB.

Under the Act, upper-tier local authorities are required to work to improve the health of their populations. This duty is an opportunity for local authorities to embed health improvement in all policy- and decision-making, which will also help address needs identified in JSNAs and priorities agreed in JHWSs.

If the health and wellbeing board does not believe that a local authority has taken account of the JSNAs or JHWSs, it can raise its concerns with the local authority.

5. Timing

JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles. Health and wellbeing boards will need to decide for themselves when to update JSNAs and JHWSs or undertake fresh ones to ensure that they are able to inform local commissioning plans over time - JSNAs and JHWSs do not need to be done from scratch every year.

6. Promoting integration between services

JHWSs can help health and social care services to be joined up with each other and with health-related services, such as housing, the economy or the environment.

Health and wellbeing boards must encourage integrated working between health and social care commissioners, and support and encourage partnership arrangements for health and social care services, such as pooled budgets, lead commissioning, or integrated provision. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way.

The NHS CB must encourage partnership arrangements between CCGs and local authorities where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities and CCGs must integrate services to achieve this, where possible. This should help encourage joint working between CCGs and local authorities in order to tackle the priorities jointly agreed in JHWSs.

The Act supports joint working by allowing local authorities to delegate functions to the health and wellbeing board. This could result in health and wellbeing boards taking on health-related functions, such as preparing housing strategies, which could help in tackling the agreed local priorities. To avoid potential conflicts of interest the power of delegation does not include health scrutiny functions.

7. Working in partnership to carry out JSNAs and develop JHWSs

Health and wellbeing boards must involve the local Healthwatch organisation and the local community, and this should be continuous throughout the JSNA and JHWS process. When involving the local community, health and wellbeing boards should consider inclusive ways to involve people from different parts of the community to ensure that differing health and social care needs are reflected and can be addressed by commissioners, recognising the need to engage with parts of the community that are socially excluded and vulnerable.

Consultation Questions

1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?
2. It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?
3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?
4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?
5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs and equality is one theme being explored.
 - a) In your view, have past JSNAs demonstrated that equality duties have been met?
 - b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?
6.
 - a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?
 - b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?
7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?
8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – What do you think the impact of this guidance will be on the behaviour of local partners?
9. How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – What do you think the impact of this guidance will be on the outcomes for local communities?



**Joint Strategic Needs
Assessments and
Joint Health and Wellbeing
Strategies – draft guidance**

Proposals for consultation

Joint Health and Wellbeing Strategies – draft guidance

Policy	Clinical	Estates
HR / Workforce Management	Commissioner Development Provider Development	IM & T Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working
Document Purpose	Consultation/Discussion	
Gateway Reference	17858	
Title	Draft Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies	
Author	Department of Health	
Publication Date	31 July 2012	
Target Audience	NHS Trust CEs, Foundation Trust CEs , Directors of PH, Local Authority CEs, Directors of Adult SSs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Healthwatch England and local pathfinders, CCG pathfinders, shadow HWBs, voluntary and community sector organisations	
Circulation List		
Description	The purpose of this publication is intended to support health and wellbeing boards and their partners in undertaking and contributing to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) within the modernised health and care system.	
Cross Ref	Joint Strategic Needs Assessments and joint health and wellbeing strategies explained. Equity and excellence: Liberating the NHS, Liberating the NHS: Legislative framework and next steps and The Government response to the NHS Future Forum report.	
Superseded Docs	N/A	
Action Required	N/A	
Timing	N/A	
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1. Purpose

The Health and Social Care Act 2012¹ ('the Act') amends the Local Government and Public Involvement in Health Act 2007 ('the 2007 Act') to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). This statutory guidance explains these duties and powers. *Further materials, including advice on good practice will be published with this statutory guidance to support health and wellbeing boards.*

2. Context

In the Act, the Government has set out a new vision for the leadership and delivery of public services – that decisions about services should be made as locally as possible, involving people who use them and the wider local community. The Act supports local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs. JSNAs and JHWSs are an important means by which they can achieve this.

The aim of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning. They will be used to help to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing².

3. Duties and powers under the 2007 Act (as amended by the Act)³

3.1 Who is responsible for JSNAs and JHWSs?

Local authorities and clinical commissioning groups (CCGs) have an equal and joint duty to prepare JSNAs and JHWSs, through the health and wellbeing board⁴. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members⁵ working together throughout the process.

Two or more health and wellbeing boards could choose to work together to produce JSNAs and JHWSs, covering their combined geographical area⁶.

Local authorities and health and wellbeing boards can decide to include additional members on the board beyond the core members⁷. Additional members, such as service providers, health and care professionals, representatives of criminal justice agencies, local voluntary and community sector organisations, or representatives of military populations and their families, can bring expert knowledge to enhance JSNAs and JHWSs.

The NHS Commissioning Board (NHS CB) must participate in JSNAs and JHWSs. Someone who is not from the NHS CB can act for it. This could be someone from a clinical CCG, if the health and wellbeing board agrees⁸.

3.2 What are Joint Strategic Needs Assessments (JSNAs)?

JSNAs are local assessments of current and future health and social care needs that could be met by the local authority, CCGs, or the NHS CB⁹. They are produced by health and wellbeing boards¹⁰, and are unique to each local area.

In preparing JSNAs and JHWSs, health and wellbeing boards must have regard to any guidance issued by the Secretary of State¹¹. This includes this guidance, and any future guidance issued.

A range of quantitative and qualitative evidence should be used in JSNAs. They can also be informed by more detailed local needs assessments such as at a district or ward level, looking at specific groups (such as those likely to have poor health outcomes), or on wider issues that affect health such as crime, community safety, planning or housing. Health and wellbeing boards can request relevant information from some members (and others)¹² when preparing JSNAs or JHWSs – and those asked have a duty to supply the information. They should ensure that staff supporting JSNAs and JHWSs have easy access to the evidence they need.

JSNAs must consider health and social care needs for the health and wellbeing board area. This includes mental health, health protection, and prevention; it could include looking at the role of personal budgets and universal advice. Therefore health and wellbeing boards will need to consider:

- the needs of the whole community including how needs vary for people at different ages, and may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services;
- wider social, environmental and economic factors that impact on health and wellbeing – such as access to green space, air quality, housing, community safety, employment; and
- what health and social care information the local community needs, including how they access it and what support they may need to understand it.

Within JSNAs, health and wellbeing boards should also consider what local communities can offer in terms of assets and resources¹³ to help meet the identified needs.

3.3 What are Joint Health and Wellbeing Strategies (JHWSs)?

JHWSs are strategies for meeting the needs identified in JSNAs¹⁴. As with JSNAs, they are produced by health and wellbeing boards¹⁵, and are unique to each local area. They should explain what health and wellbeing priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. This is not about taking action on everything at once, but about setting priorities for joint action and making a real impact on people's lives.

Outcome measures from the separate NHS, Adult Social Care and Public Health Outcomes Frameworks, the Commissioning Outcomes Framework and outcome strategies, will be useful to help inform joint priorities, although they should not overshadow local evidence.

In preparing JHWSs, health and wellbeing boards must have regard to the Secretary of State's mandate¹⁶ to the NHS CB¹⁷.

3.4 Using JSNAs and JHWSs

JSNAs and JHWSs are fundamental to the new system because of how they are used, and the evidence base they provide for the planning of services.

CCGs, the NHS CB, and local authorities' plans for commissioning services must be informed by JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWSs, CCGs, the NHS CB and LAs must be able to explain why¹⁸.

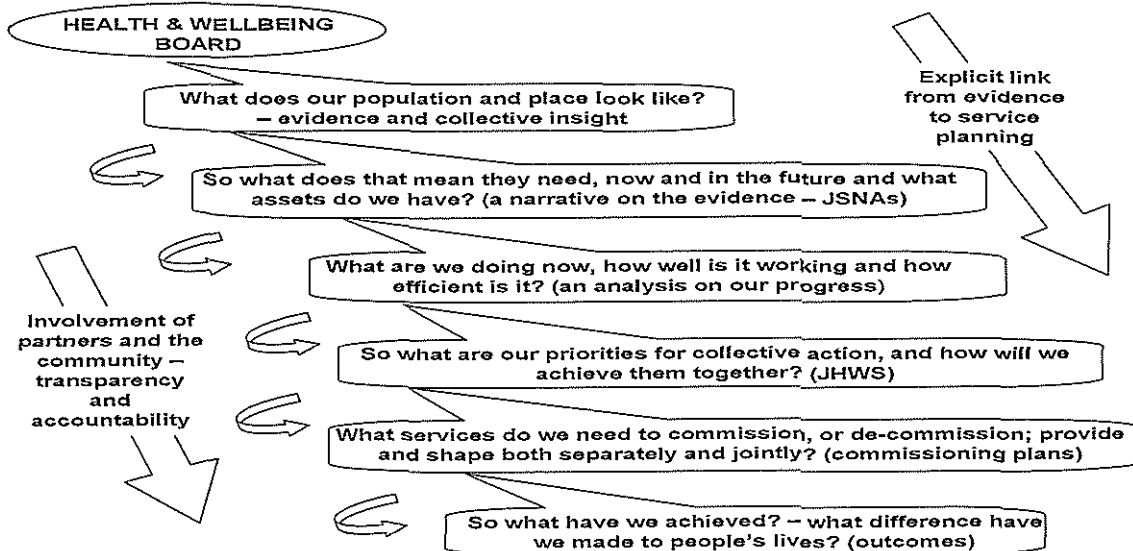
CCGs must also involve the health and wellbeing board in the preparation of (or when making significant changes to) their commissioning plans¹⁹. CCGs must consult health and wellbeing boards on whether their commissioning plans take proper account of the JHWSs²⁰. When asked, health and wellbeing boards must give a view on this, which must be included in the published plan²¹. It would be good practice for local authorities and the NHS CB to also involve health and wellbeing boards when developing their plans for commissioning to make sure that each plan is informed by the JHWS. By their nature, commissioning plans will need to cover a broad range of services – inclusion of plans for services which meet needs in addition to those prioritised in the JHWS does not in itself mean the plans do not take account of the JHWS

If a health and wellbeing board thinks that a CCG has not taken proper account of the relevant JHWSs it can make this known in very clear and certain terms to the CCG, and also to the NHS CB²². As mentioned above, the CCG must be able to justify any parts of their plans which are not consistent. The NHS CB can take action if it believes that the plan is not in line with the JHWS, without a good reason²³.

Under the Act, upper-tier local authorities are required to work to improve the health of their populations²⁴. This duty is an opportunity for local authorities to embed health improvement in all policy- and decision-making, which will also help address needs identified in JSNAs and priorities agreed in JHWSs.

If the health and wellbeing board does not believe that a local authority has taken account of the JSNAs or JHWSs, it can raise its concerns with the local authority²⁵.

Figure 1 – How JSNAs, JHWSs and commissioning plans fit together



3.5 Timing

JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles²⁶. Health and wellbeing boards will need to decide for themselves when to update JSNAs and JHWSs or undertake fresh ones to ensure that they are able to inform local commissioning plans over time - JSNAs and JHWSs do not need to be done from scratch every year.

4. Promoting integration between services

JHWSs can help health and social care services to be joined up with each other and with health-related services²⁷, such as housing, the economy or the environment.

Health and wellbeing boards must encourage integrated working between health and social care commissioners, and support and encourage partnership arrangements for health and social care services²⁸, such as pooled budgets, lead commissioning, or integrated provision²⁹. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way³⁰.

Health and wellbeing boards can encourage close working between commissioners of health-related services and themselves; and commissioners of health and social care services³¹. This could potentially involve considering the commissioning of health-related services either with or by a broad range of local partners, such as district councils, local authority housing commissioners, local community safety partnerships, Police and Crime Commissioners, local probation trusts, prisons, children's secure estates and schools. In this way health and wellbeing boards can use the priorities agreed in JHWSs to influence other services that also affect health to improve outcomes and also to encourage the integration of services.

The NHS CB must encourage partnership arrangements between CCGs and local authorities³² where it considers this would ensure the integrated provision of health services and that this would improve the quality of services or reduce inequalities³³ and CCGs must integrate services to achieve this, where possible. This should help encourage joint working between CCGs and local authorities in order to tackle the priorities jointly agreed in JHWSs.

The Act supports joint working by allowing local authorities to delegate functions to the health and wellbeing board³⁴. This could result in health and wellbeing boards taking on health-related functions, such as preparing housing strategies, which could help in tackling the agreed local priorities. To avoid potential conflicts of interest the power of delegation does not include health scrutiny functions³⁵. Health scrutiny is an important way that the local authority (and through it, local people) can hold some health and wellbeing board members to account for delivering health services, or consider how the JSNA and JHWS process is used to plan services.

JHWSs could consider how services might be reshaped and redesigned to address needs identified in JSNAs and reduce inequalities. Using local JSNA evidence and agreed JHWS priorities means local service change plans will complement other local commissioning, and this will encourage greater integration across health and social care services.

5. Working in partnership to carry out JSNAs and develop JHWSs

Health and wellbeing boards for county councils must involve the relevant district councils in developing JSNAs³⁶. They should seek to work with district councils when preparing JHWSs and to agree with district councils how they will do this.

Health and wellbeing boards must involve the local Healthwatch organisation³⁷ and the local community³⁸, and this should be continuous throughout the JSNA and JHWS process. When involving the local community, health and wellbeing boards should consider inclusive ways to involve people from different parts of the community to ensure that differing health and social care needs are reflected and can be addressed by commissioners, recognising the need to engage with parts of the community that are socially excluded and vulnerable³⁹.

Health and wellbeing boards should also work closely with other partners such as Police and Crime Commissioners, criminal justice agencies, youth justice services, troubled families coordinators, local authority housing services, schools, voluntary and community organisations, Local Nature Partnerships, representatives of military populations and their families; and Department for Work and Pensions local partnership teams⁴⁰, to get a thorough understanding of local needs and how to address them.

Local Healthwatch and the voluntary and community sector (including organisations that represent specific groups) can provide information to help JSNAs better reflect the needs and views of people in vulnerable circumstances and this can support the development of a JHWS to meet those needs. Most local areas will have a Compact agreement⁴¹ setting out how local authorities and the NHS will work with voluntary and community organisations for mutual benefit and these should be considered during the process.

Service providers⁴² can also provide important evidence about local needs and take action to improve outcomes, although health and wellbeing boards will need to consider how any conflicts of interest will be managed.

6. Transparency and accountability

JSNAs and JHWSs must be published⁴³. Making them public will explain to the local community what the health and wellbeing board's assessment of the local needs and assets is and what their proposals to address them are, with clear measures of progress over time. It will also show what evidence has been considered, what priorities for action have been agreed and why. The publication should include a summary of community views, how they have been used; and also whether any other relevant views have been considered.

Sharing the analysis behind JSNAs, and (if appropriate) safely making the data they have used accessible, will help health and wellbeing boards make their decision-making process transparent to their community and to be held to account⁴⁴.

7. Other duties

As a local authority committee, a health and wellbeing board must meet the Public Sector Equality Duty under the Equality Act 2010 throughout the JSNA and JHWS process. This is not just about how the community is involved, but about considering the effects decisions have or are likely to have on people with protected equality characteristics⁴⁵, and perhaps other groups identified as vulnerable in JSNAs. Integrating equality considerations into the JSNA and JHWS process, can help public sector organisations to discharge their responsibilities under the Public Sector Equality Duty⁴⁶.

Preparing JSNAs and JHWSs can support other legal duties, for example, in relation to the reduction of crime (including antisocial behaviour)⁴⁷. They can also contribute to other local partnerships such as Community Safety Partnerships (CSPs)⁴⁸ or where they exist, Local Enterprise Partnerships (LEPs)⁴⁹.

8. Conclusion

By having full engagement of all health and wellbeing board members, wider local partners and the local community, JSNAs will provide a unique picture of local needs and assets. By agreeing joint local priorities in JHWSs to inform joint action to tackle these needs, health and wellbeing boards will be able to lead action to improving people's lives and reduce inequalities.

9. Consultation Questions

1. Does the guidance translate the legal duties in a way which is clear in terms of enabling an understanding of what health and wellbeing boards, local authorities and CCGs *must* do in relation to JSNAs and JHWSs?
2. It is the Department of Health's (DH's) view that health and wellbeing boards should be able to decide their own timing cycles for JSNAs and JHWSs in line with their local circumstances rather than guidance being given on this; and this view was supported during the structured engagement process. Does the guidance support this?
3. Is the guidance likely to support health and wellbeing boards in relation to the content of their JSNAs and JHWSs?
4. Does the guidance support the principle of joined-up working, between health and wellbeing board members and also between health and wellbeing boards and wider local partners in a way that is flexible and suits local circumstances?
5. The DH is working with partners to develop wider resources to support health and wellbeing boards on specific issues in JSNAs and JHWSs, and equality is one theme being explored.
 - a) In your view, have past JSNAs demonstrated that equality duties have been met?
 - b) How do you think the new duties and powers, and this guidance will support health and wellbeing board members and commissioners to prevent the disadvantage of groups with protected characteristics, and perhaps other groups identified as in vulnerable circumstances in your area?
6.
 - a) In your view, have JSNAs in the past contributed to developing an understanding of health inequalities across the local area and in particular the needs of people in vulnerable circumstances and excluded groups?
 - b) What supportive materials would help health and wellbeing boards to identify and understand health inequalities?
7. It is the DH's view that health and wellbeing boards should make use of a wide range of sources and types of evidence for JSNAs and they should be able to determine the best sources to use according to local circumstances. This view was supported during the structured engagement process. What supportive materials would help health and wellbeing boards to make the best use of a wide range of information and evidence to reach a view on local needs and assets, and to formulate strategies to address those needs?
8. What do you think NHS and social care commissioners are going to do differently in light of the new duties and powers, and as a result of this guidance? – what do you think the impact of this guidance will be on the behaviour of local partners?

9. How do you think your local community will benefit from the work of health and wellbeing boards in undertaking JSNAs and JHWSs? – what do you think the impact of this guidance will be on the outcomes for local communities?

10. Have your say

The Government has committed to publishing guidance on enhanced JSNAs and JHWSs which are to be undertaken by health and wellbeing boards. The Government wants to hear your views on whether this draft guidance supports health and wellbeing boards, and their partners in understanding the purpose of JSNAs and JHWSs, and the duties and roles of health and wellbeing boards in undertaking them.

Deadline for comments

This is an eight-week consultation running from **31 July 2012** to **28 September 2012**. In order to be considered all comments must be received by **28 September 2012**. Your comments may be shared with colleagues in the Department of Health and/or be published in a summary of responses. Unless you specifically indicate otherwise in your response, we will assume that you consent to this and that your consent overrides any confidentiality notice generated by your organisation's email system.

The eight-week consultation period (which is shorter than the full 12-week period set out in the HM Government Code of Practice on Consultation) is because the Government has developed the current draft in collaboration with emerging health and wellbeing boards and undertook a structured engagement exercise during January and February of this year. Over 100 responses were received as a result of the exercise and the draft guidance has been revised to reflect these.

Shadow health and wellbeing boards, once established, will want to consider and prepare for carrying out JSNAs and JHWSs ready for April 2013, when the relevant provisions of the Health and Social Care Act 2012 will come into effect. An eight-week consultation will allow the Government to publish the final guidance in time to support preparations for April 2013.

Consultation timeline

31 July	Consultation document published
28 September	Consultation ends – responses must be returned to the Department of Health by this date
Autumn 2012	Final guidance document and response to consultation published

How to respond

Please submit your responses online at [JSNAs and JHWSs draft statutory guidance consultation](#) or by email to JSNAandJHWS@dh.gsi.gov.uk

OR

By hard copy to
JSNA and JHWS development lead
People, Communities and Local Government,
Department of Health
Wellington House
133-155 Waterloo Road
London
SE1 8UG

When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear whom the organisation represents and, where applicable, how the views of members were assembled.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information (FOI) Act 2000, the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOI Act, there is a statutory Code of Practice with which public authorities must comply, and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in the majority of cases, this will mean that your personal data will not be disclosed to third parties.

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process
- analyse responses carefully and give clear feedback to participants following the consultation
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

[Link to consultation Code of Practice](#)

After the consultation

Once the period is complete, the Department of Health will consider the comments it has received, and the response will be published alongside the final guidance.

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at:

[Link to DH Consultations](#)

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

Contact Consultations Coordinator
 Department of Health
 3E48, Quarry House
 Leeds
 LS2 7UE
E-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter**.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Impact assessment

The [impact assessment which accompanied the Health and Social Care Bill](#) assesses the costs, benefits and risks of the enhanced JSNA process and the new duty to develop JHWSs. This guidance, which supports health and wellbeing boards and their partners in undertaking and contributing to JSNAs and JHWSs, will help to support the realisation of the costs and benefits set out in this impact assessment.

¹ The relevant parts of which are expected to come into force on 1 April 2013.

² More information can be found in *Fair Society, Healthy Lives (the Marmot Review), 2010*

³ The duties required by, and the powers conferred by the Act, the 2007 Act (as amended by the Act), and the NHS Act 2006 (as amended by the Act) relating to the preparation of JSNAs and JHWSs are summarised and referenced throughout. Where 'must' is used, this indicates something required by one or other of the Acts. Where 'can' is used, this indicates a power in one or other of the Acts. Where 'could' is used, this indicates an example of how that power could be used if appropriate. Where 'should' is used it indicates something that is statutory guidance – something that is not required by the Acts, but it is recommended in order to achieve the spirit of the Acts or in accordance with sector-led best practice, and to which there is a statutory duty to have regard.

⁴ The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193); and the Act – section 196.

⁵ The Act – section 194: each upper tier local authority in England must set up a health and wellbeing board, with a core membership of: a) at least one elected representative – councillor(s) nominated by the leader or the mayor of the local authority (and / or the leader or mayor themselves), or in some cases by the local authority; b) a representative of each clinical commissioning group (CCG) whose area is within or partly within, or coinciding with the local authority area – CCGs may be required to appoint representatives to more than one health and wellbeing board if their area falls within more than one local authority area; c) the directors of public health, adult social services, and children's services; and d) a representative of the local Healthwatch organisation.

⁶ The Act – section 198(a) allows two or more health and wellbeing boards to make arrangements for any of their functions to be exercised jointly.

⁷ 'Core members' is a reference to the members in the Act (section 194) – see Footnote 4. A local authority or health and wellbeing board can appoint other members to the board.

⁸ The duty on the NHS CB to appoint a representative to participate in JSNAs and JHWSs is in section 197(1) and (2) of the Act. Section 197(5) provides that the representative may be someone who is not a member or employee of the NHS CB, with the health and wellbeing board's agreement.

⁹ The 2007 Act – section 116 (as amended by the Act – section 192).

¹⁰ The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JSNAs, the source of this is a duty imposed on the local authority and CCG.

¹¹ The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).

¹² The Act – section 199. Health and wellbeing boards have the power to request information from the local authority, or the CCGs and local Healthwatch organisations represented on the board. They also have the power to request information from members, or those organisations represented by members other than the core members. The request must be made in order to enable or assist health and wellbeing boards to perform their functions – in this context, to enable or assist health and wellbeing boards to undertake JSNAs and JHWSs.

¹³ There are a range of assets within local communities that can help meet identified needs and impact on the wider determinants of health. These could include formal or informal resources, capacity in other organisations or the community; such as the ability of groups to take greater control of their own health or manage long-term conditions. *Supporting communities and encouraging people to improve their health and wellbeing is central to achieving the Government's vision. Strong communities can improve health and wellbeing, and reduce inequalities (Foot, J., What makes us healthy? The asset-based approach in practice: evidence, action, evaluation, 2012).* There are a number of methods being developed, (Local Area Co-ordination, Connected Care or Asset-Based Community Development) – these examples may be useful to health and wellbeing boards.

¹⁴ The 2007 Act – section 116A (as inserted by the Act – Section 193).

¹⁵ The duty falls on local authorities and CCGs but must be discharged by health and wellbeing boards (the Act – section 196(1)). Where the guidance refers to something that health and wellbeing boards must do in relation to JHWSs, the source of this is a duty imposed on the local authority and CCG.

¹⁶ This is currently being consulted on.

¹⁷ The 2007 Act – section 116A (as inserted by the Act – section 193).

¹⁸ The 2007 Act – section 116B (as inserted by the Act – section 193) requires local authorities and CCGs, in exercising any functions and the NHS CB, in exercising its commissioning functions in relation to the local area, to have regard to any JSNA and JHWS which is relevant to the exercise of those functions.

¹⁹ The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to involve each relevant health and wellbeing board. A relevant health and wellbeing board, in relation to a CCG, is one which is established by a local authority whose area coincides with, or includes the whole or any part of, the area of the CCG – the NHS Act 2006 - section 14Z11 (as inserted by the Act - section 26).

²⁰ The NHS Act 2006 – section 14Z13 inserted by section 26 of the Act. The duty on the CCG is to consult each relevant health and wellbeing board on whether the draft commissioning plan takes proper account of each JHWS published by the board which relates to the period (or any part of the period) to which the plan relates..

²¹ The NHS Act 2006 – section 14Z13 (as inserted by section 26 of the Act). The CCG must include a statement of the final opinion of each relevant health and wellbeing board consulted upon publication of the plan

²² The NHS Act 2006 – section 14Z13 (as inserted by the Act - section 26).

²³ Action could be taken if the NHS CB has reason to believe that the CCG might fail, have failed, be failing to discharge any of its functions. It could require documents, information or an explanation (the NHS Act 2006 – sections 14Z18 or 14Z19).

²⁴ The NHS Act 2006 – section 2B (as inserted by the Act - section 12).

²⁵ The Act – section 196.

²⁶ The NHS Act 2006 – sections 14Z1 and 14Z24 (as inserted by of the Act – section 26). CCGs must develop commissioning plans to be in place before the beginning of each financial year (or before a date directed by the NHS CB as regards the financial year of establishment) and most local authorities also plan yearly.

²⁷ The 2007 Act – section 116A (as inserted by the 2012 Act – section 193). Health-related services are those that are not health or social care services, but may have an effect on health outcomes, as defined in the Act – section 195; such as transport, planning or environmental services insofar as they may have an effect on health.

²⁸ The Act – section 195.

²⁹ The NHS Act 2006 – section 75.

³⁰ The 2007 Act – section 116A (as inserted by the Act – section 193).

³¹ The Act – section 195.

³² And also between CCGs where this would lead to improvements and integrated services, which may be prioritised in JHWSs. The NHS Act 2006 - section 13N (as inserted by the Act – section 23).

³³ The NHS Act 2006 – section 13N (as inserted by the Act – section 23). This also applies where the NHS CB considers that partnership arrangements would lead to integrated provision of health services with social care or health-related services, and that this would improve the quality of services or reduce inequalities.

³⁴ The Act – section 196.

³⁵ The Act – section 196.

³⁶ The 2007 Act – section 116 (as amended by the Act – section 192).

³⁷ The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local Healthwatch organisation for the area is separate to (ie, not discharged only by) local Healthwatch being represented on the health and wellbeing board.

³⁸ The 2007 Act – section 116 (as amended by the Act – sections 192) and section 116A (as inserted by the Act – section 193). The duty to involve the local community is a requirement to involve the people who live or work in the area, and does not distinguish between children and adults.

³⁹ Such as people with disabilities, homeless people, offenders, victims of crime, or Gypsies and Travellers.

⁴⁰ Serving both working age (through Jobcentres), and pension age clients.

⁴¹ More information is provided by [Compact Voice](#).

⁴² For instance Foundation Trusts, care homes; and providers of domiciliary care services.

⁴³ The 2007 Act – section 116 (as amended by the Act – section 192) and section 116A (as inserted by the Act – section 193).

⁴⁴ Government [Open Data policies](#) provide more information.

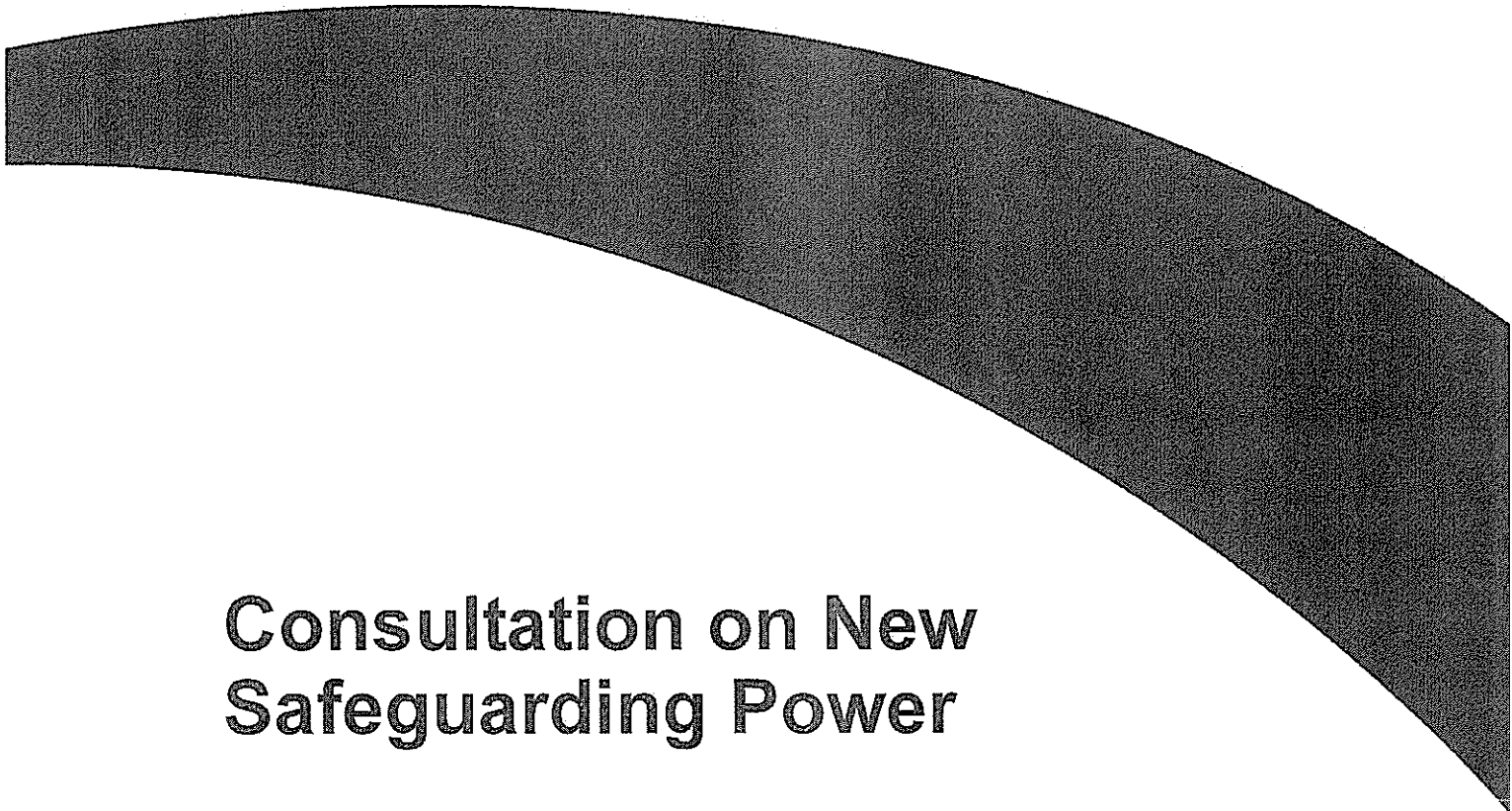
⁴⁵ This includes age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex, and sexual orientation.

⁴⁶ As public authorities, both local authorities and CCGs have general and specific duties under the Equality Act 2010, designed to integrate consideration of advancing equality; eliminating discrimination and fostering good relations into the day-to-day business of public authorities; and to help them improve their performance on the general equality duty by improving their focus and transparency. These duties will apply to health and wellbeing boards as a committee of the local authority, including when discharging functions on behalf of the local authority and CCGs. Local authorities remain responsible for ensuring that the general and specific equality duties are met.

⁴⁷ The Crime and Disorder Act 1998 ('the 1998 Act') – section 6 places a statutory duty on responsible authorities (including local authorities, the Police, Probation Trusts, Fire and Rescue Authorities, and from April 2013 CCGs) to formulate and implement strategies for the reduction of crime and disorder (including anti-social behaviour); for combating the misuse of drugs, alcohol and other substances; and for the reduction of reoffending.

⁴⁸ CSP is a term used to refer to the group of responsible authorities under section 5 of the 1998 Act which have duties to prepare the strategies referred to in footnote 50. From April 2013 CCGs will replace PCTs as responsible authorities due to amendments made to section 5 of the 1998 Act by the Act – Schedule 5 paragraph 84. They offer a way for all partners to focus on improving health and wellbeing, and crime outcomes together.

⁴⁹ LEPs are non-statutory partnerships between local authorities and business, – [Local Growth White Paper, 2010](#)



Consultation on New Safeguarding Power

Introduction

1. The draft Care and Support Bill includes a proposed duty on local authorities to make enquiries where there is a safeguarding concern. It states that local authorities “must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken.”
2. This consultation seeks your views on whether or not there should be a new power to support this duty. This could be in the form of a power of entry, enabling the local authority to speak to someone with mental capacity who they think could be at risk of abuse and neglect, in order to ascertain that they are making their decisions freely.¹
3. The draft Bill contains a number of firm proposals, including a duty of co-operation and partnership working between local authorities, police and health services. It is not our intention to introduce further powers of entry unless a compelling case can be made.

Background

4. In 2009, the Government consulted on a wide range of adult safeguarding issues as part of the review of the statutory guidance *No Secrets*. Of the 212 respondents on this particular issue, 60% agreed that there should “be a power to enter premises where it is suspected that a vulnerable adult is being abused.” 27% did not support this. The consultation question did not distinguish between people with mental capacity and those without.
5. In relation to new compulsory powers, the Law Commission’s review of adult social care law in 2011 concluded that it was an issue outside the scope of its consideration. The Law Commission’s recommendation was that the statute should not include any new compulsory or emergency powers, unless the Government identified the need for such powers.² We are responding to that point through this consultation.
6. The Law Commission recommended placing a duty on local social services authorities to investigate or make enquiries about adult protection concerns. The purpose of the enquiry is to establish what action (if any) is required, and to establish who should take such action. The draft Care and Support Bill contains a clause to this effect.
7. As recommended by the Law Commission³, the draft Bill also proposes repealing Section 47 of the 1948 National Assistance Act. Section 47 gives a power to remove someone from his or her home in certain circumstances. Enacted in a very different era, its language and intentions are not compatible with our current approach to community-based support that promotes and protects people’s human rights.
8. With the proposed repeal of Section 47, and the new duty to make enquiries, we want to explore whether Local Authorities have sufficient power to gain access to a person who may be at risk of abuse where this is appropriate and not already provided for in existing legislation.

¹ For people who lack capacity alternative provision is made under the Mental Capacity Act 2005.

² Recommendation 41, *Adult Social Care*, Law Com No 326, page 122

³ Recommendation 42, *Ibid*, page 130

Scenario

9. The proposal on which we are consulting applies where a local authority has reasonable cause for concern that a person with capacity is experiencing abuse or neglect, and someone else in the property is preventing the local authority from speaking with that person.
10. In such circumstances, we are seeking your views on whether the local authority should be able to apply for a warrant to enter the premises and speak with that person alone. This power would support local authorities' to carry out the new duty to make enquiries, which is in the draft Bill.

What is the current position?

11. Protection in law does exist in cases of coercion and undue pressure, including for those with the mental capacity to make their own decisions. Even where there are no formal statutory powers, the High Court has inherent jurisdiction to act.
12. This was confirmed by the Court of Appeal in March 2012 in a case where a local authority took legal action to protect a couple in old age from their son, even though the couple said they did not want to take action and at the time both had mental capacity to make that decision.⁴ The local authority was able to call upon the High Court's inherent jurisdiction and the Court issued a detailed injunction to protect the couple.
13. However, we do not believe leaving such cases to be resolved on a case-by-case basis using the Court's inherent jurisdiction is a satisfactory solution. Resorting to the courts in every instance could increase the caseload of courts, result in differing outcomes, be expensive for local authorities and is likely to be extremely disempowering for individuals. If we establish that a proportionate and effective legislative solution could help resolve this issue, it would not be necessary to rely on case law to settle the matter.

Scope

14. This is a very complex issue. The legislation we are considering is at the interface between issues of protection and civil liberties. We are not looking to over-ride the choices of people with capacity who make decisions professionals may disagree with – this is about circumstances where the ability to make a choice is believed to be restricted by the behaviour of another person.
15. Local authorities are not without powers in this area. They currently undertake a range of measures to deal with safeguarding situations. The majority of these interventions do not require statutory powers, and where they do, the alternative options such as the Mental Capacity Act 2005 are available and more appropriate. Other existing legislation that can and is being used to safeguard adults includes the Police and Criminal Evidence Act 1984, Criminal Justice Act 1988, the Mental Capacity Act 2005, the Fraud Act 2006, the Mental Health Act 1983, the Domestic Violence, Crime and Victims Act 2004, the Protection of

⁴ *DL v Local Authority* [2012] EWCA Civ 253

Freedoms Act 2012, and health and safety at work legislation. However, there is a view that these options do not cover all eventualities and leave a gap in the legislative framework.

16. We are not seeking views on the content of clauses in the draft Care and Support Bill, for which there is a separate consultation.

17. We do not want to intervene in people's lives unnecessarily. This proposal is about giving people a voice and empowering them to make decisions without coercion. It aims to empower local authorities to effectively carry out the new duty of enquiry, and give them a course of action if someone prevents them from doing so. It gives an opportunity for local authorities to offer the right information and advice and for people who are unable or unwilling to ask for help to have their voices heard.

Human Rights considerations

18. Any new legislation needs to be compatible with the European Convention on human rights (ECHR). The following human rights considerations are relevant.

19. Article 2 of the ECHR (right to life) and Article 3 (prohibition of inhuman and degrading treatment) impose positive obligations on the state to take measures to protect citizens which this proposal would support.

20. We are not proposing any new power of removal or detention, so we do not anticipate any conflict with Article 5 ECHR (right to liberty).

21. Article 8 (right to respect for private and family life) means any intervention must pursue a legitimate aim and the intervention must be at a level which can be justified and proportionate to the pursuit of the legitimate aim. Any power of entry would be for the legitimate aim of ensuring that we enable the person in question to express his or her wishes without undue pressure or coercion. We will consider what safeguards should be provided to ensure the intervention is justified and proportionate.

Consultation questions

Question 1: Do you agree that there is a gap in the proposed legislative framework for people with mental capacity, which this power would address?

Question 2: What are your views on the proposal that there should be a new power of entry, enabling the local authority to speak to someone with mental capacity who they think could be at risk of abuse and neglect, if a third party prevents them from doing so?

Question 3 (for care and support professionals working in adult safeguarding): How many times in the last 12 months, have you been aware of a situation where, had this power existed, it would have been appropriate to use it? What were the circumstances?

Question 4: What safeguards would we need to ensure local authorities use such a power effectively and appropriately?

For example, would the following provide adequate safeguards?

- *A warrant would be applied for from a Circuit Judge (e.g. a nominated judge of the Court of Protection).*
- *The local authority would present the court with evidence of the need for the warrant.*
- *The local authority would ensure that there is a process by which the occupiers of the premises understand that they can complain about the way in which a power has been used. The local authority would have to verbally inform the affected persons how they might access that process*

Question 5: Do you have any other comments?

The consultation will run from **11 July 2012** until **12 October 2012**.

Please submit your comments to **SafeguardingConsultation@dh.gsi.gov.uk** or:

Quality and Safety Team
Department of Health
124 Wellington House
133-155 Waterloo Road
London SE1 8UG

Comments received after 12 October 2012 will not be considered.

Consultation on New Safeguarding Power – Draft response

Consultation questions

Question 1: Do you agree that there is a gap in the proposed legislative framework for people with mental capacity, which this power would address?

Our view is that there is a gap in the proposed framework and in the Mental Capacity Act for those with capacity and those that lack capacity.

Paragraph 4.59 of the Mental Capacity Act Code of Practice states that if somebody refuses to open their door, it cannot be forced. There is no consideration of a third party preventing access to assess capacity.

Question 2: What are your views on the proposal that there should be a new power of entry, enabling the local authority to speak to someone with mental capacity who they think could be at risk of abuse and neglect, if a third party prevents them from doing so?

This is an extreme measure which should be used only when there is evidence to suggest that an adult may be being abused or neglected and where access to assess and consult the adult is blocked by a third party. This power would be used to;

- Ascertain the views of the vulnerable adult
- Uncover any duress
- Offer advice and support if required.

It is often unclear, when concerns about abuse are raised, whether or not the alleged victim has capacity related to the situation or circumstances of the alleged abuse. In order to make enquiries into concerns, as set out in the proposed legislation, it is necessary to establish the views of the adult i.e. do they consider if they are being abused and do they want help. In order to do this we need to have access to the person. In most cases and depending on the circumstances and the disabilities of the person, this can be done without seeing them. However, there are times when it is essential to see the person to do this.

Recent case law has highlighted the way in which, even if someone has cognitive capacity and hence falls outside the protection of the Mental Capacity Act, they may still need protection because of coercion or some other factor depriving them of free choice.

Question 3 (for care and support professionals working in adult safeguarding): How many times in the last 12 months, have you been aware of a situation where, had this power existed, it would have been appropriate to use it? What were the circumstances?

No referrals in the last 12 months where we would have needed to use the power.

Question 4: What safeguards would we need to ensure local authorities use such a power effectively and appropriately?

For example, would the following provide adequate safeguards?

- *A warrant would be applied for from a Circuit Judge (e.g. a nominated judge of the Court of Protection).*
- *The local authority would present the court with evidence of the need for the warrant.*
- *The local authority would ensure that there is a process by which the occupiers of the premises understand that they can complain about the way in which a power has been used. The local authority would have to verbally inform the affected persons how they might access that process*

The above measures would, in our view, be adequate to safeguard the rights of individuals. A similar system has been in place for some time under S135 of the Mental Health Act and has in our experience proved effective. In our view a magistrate rather than a judge would be preferable to grant a warrant as they are more accessible.

Question 5: Do you have any other comments?

N/A